

EXHIBIT J

1 UNITED STATES DISTRICT COURT
2 FOR THE EASTERN DISTRICT OF TENNESSEE
3 CASE NO. 3:19-cv-00041
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5 - - -
6 SCOTT ALLEN TOMEI, :
7 Plaintiff, :
8 vs. :
9 PARKWEST MEDICAL CENTER and :
10 COVENANT HEALTH, :
11 Defendants.:
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15 DEPOSITION OF MARIE PATTERSON WILSON
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1 D E P O S I T I O N

2 The deposition of MARIE PATTERSON WILSON,
3 taken at the request of the Plaintiff, for purposes
4 of discovery, pursuant to the Tennessee Rules of
5 Civil Procedure on the 18th Day of December, 2019,
6 at the offices of Arnett, Draper & Hagood, LLP, 800
7 S. Gay Street, 2300 First Tennessee Plaza,
8 Knoxville, Tennessee 37901 before Catherine
9 Golembeski, Registered Professional Reporter and
10 Notary Public at Large for the State of Tennessee.

11 It is agreed that the deposition may be
12 taken in machine shorthand by Catherine Golembeski,
13 Licensed Court Reporter and Registered Professional
14 Reporter and Notary Public, and that she may swear
15 the witness and thereafter transcribe her notes to
16 typewriting and present to the witness for
17 signature, and that all formalities touching
18 caption, certificate, filing, transmission, etc.,
19 are expressly waived.

20 It is further agreed that all objections
21 except as to the form of the questions are reserved
22 to on or before the hearing.

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EXAMINATION

1 (Proceedings began at 10:22 a.m.)

2 MARIE PATTERSON WILSON,

3 called as a witness at the instance of the
4 Plaintiff, having been first duly sworn, was
5 examined and deposed as follows:

6 EXAMINATION BY MR. ROZYNSKI:

7 Q. Good morning.

8 A. Good morning.

9 Q. My name is Andrew Rozyński. I'm with
10 the law firm of Eisenberg and Baum. And I
11 represent Scott Tomei in the matter against
12 Parkwest. I brought you here to take your
13 deposition.

14 Have you ever had a deposition taken
15 before?

16 A. I have not.

17 Q. Since this is your first time, I'm
18 going to go over some of the ground rules so we
19 have a smooth deposition.

20 As you can see, the court reporter is
21 taking down everything that we're saying. She's
22 making a transcript. She's also sworn you under
23 oath, which means you swore to tell the truth. And
24 if you knowingly say anything that's false, that it
25 could be subject to penalties. Okay?

1 A. Okay.

2 Q. So, also, it's really important that we
3 have a clear record, since she is making a
4 transcript, so that we have clear questions and
5 answers. Sometimes you might know the question
6 that I'm about to ask, but I just ask that you hold
7 off on your answer until the question is complete
8 so that the transcript would have a clear question
9 and an answer. I'll wait until I ask my next
10 question once you finish your answer. Okay?

11 A. Okay.

12 Q. There's also other things that do drive
13 court reporters crazy like saying uh-huh, uh-uh,
14 shaking your head, nodding your head instead of
15 giving a verbal response. So I just ask that you
16 give a verbal response to whatever question that's
17 pending. Okay?

18 A. Okay.

19 Q. Also it's not a memory test. If you
20 don't remember it's okay to say you don't remember.
21 I do want your best recollection. So it's
22 important that you give that. So, for instance, if
23 I ask you a question about when something happened,
24 and you recall it happened in October of 2017 but
25 you don't know the exact date. Instead of saying I

1 don't remember when that happened, just give your
2 best recollection. Okay?

3 A. Okay.

4 Q. I don't expect this to be a long
5 deposition, but if you need to take a break at any
6 time let me know and we'll take a break, just not
7 in the middle of the question. Okay?

8 A. Okay.

9 Q. So please state your full name and
10 address for the record?

11 A. Marie Paterson Wilson, 9200 Brandywine
12 Circle, Knoxville, Tennessee 37922.

13 Q. And who's your current employer?

14 A. Parkwest Medical Center.

15 Q. How long have you worked for them?

16 A. Three years in September. I started in
17 September of 2016.

18 Q. Okay. And what is your current title
19 there?

20 A. RN or registered nurse.

21 Q. Okay. And what are your general job
22 duties as a registered nurse?

23 A. I take care of patients on the floor.
24 I execute doctor's orders as far as medications
25 that they need to be given. I assess my patients.

1 I educate my patients. I chart on my patients a
2 lot. I work with other nurses and nursing
3 assistants on the floor.

4 Q. Have you ever had a patient who only
5 spoke Spanish?

6 A. Not only Spanish. I have had patients
7 who Spanish is their first language, but they've
8 been able to speak to me in English.

9 Q. Okay. Have you ever had a patient who
10 only spoke another language?

11 A. Not only another language, no. They've
12 -- all of my patients that I've had have been able
13 to speak some English to me.

14 Q. Are you trained in any way that if
15 someone's primary language is a language other than
16 English, to insure that they have an interpreter?

17 A. Yes. We have an education system
18 through Covenant where we're taught how to use the
19 video conferencing system, to get an interpreter if
20 we need to.

21 It's also my understanding that we can
22 ask for or request, you know, physical interpreters
23 for patients who speak other languages.

24 Q. Okay. And are you trained that if
25 someone identifies as their primary language

1 something other than English, that you should do
2 all communications with them in their language --
3 in there primary language?

4 A. I'm trained to -- I'm trained to help
5 the patient as best I can. And if they request or
6 let me know they need another form of
7 communication, then I can follow through with that
8 or if I feel that I'm not able to communicate with
9 them what I need to communicate, then I can go
10 those other avenues.

11 Q. Okay. So you're not trained that you
12 should communicate with someone, if someone
13 identifies as their primary language is something
14 other than English, that you should always
15 communicate with them in that language. You're not
16 trained on that?

17 A. We're trained to communicate with them
18 in the way that they want to communicate. So if
19 they specifically ask us to use another form of
20 communication, then we're trained to accommodate
21 them in that request. I don't make assumptions. I
22 let them -- if we're able to communicate, then I
23 let them tell me how they want to communicate. If
24 I go into a room and they can't speak my language
25 at all, then I'll go to other avenues.

1 Q. Okay. So just to be clear, you are not
2 trained to communicate in someone's primary
3 language once they've identified that their current
4 language is something other than English for all
5 communications?

6 MR. YOUNG: I think it's been asked and
7 answered.

8 You may answer.

9 A. Okay. I'm sorry. I'm trained that if
10 a patient can not communicate with me and requests
11 another form of communication, I accommodate that
12 request or do everything I can to accommodate that
13 request.

14 Q. So my question has nothing to do with
15 accommodating a request. My question was: If
16 someone identifies as a primary language other than
17 English, are you trained to communicate with them
18 every time through that primary language? That's a
19 yes or no or if you can't answer yes or no.

20 A. I'm trained to communicate with the
21 patient how they ask to be communicated with.

22 Q. Okay. So identifying as a primary
23 language, I just don't understand, because if
24 someone primarily communicates in another language
25 other than English, how can they tell you that?

1 A. They would -- I would know that because
2 I wouldn't be able to communicate with them. If I
3 say, can you tell me how you're feeling? And their
4 face is blank, they don't understand me at all, and
5 I can't communicate with them, then I'll go down
6 the avenues of other forms of communication working
7 with the video system or other things.

8 **Q. Have you heard of a communication**
9 **assessment tool?**

10 A. I don't know that we -- I don't know
11 that I have.

12 **Q. Okay. Have you ever filled out a form**
13 **where you present it to someone who speaks a**
14 **language other than English where they fill it out**
15 **and make a request about what kind of**
16 **accommodations they may need?**

17 A. I haven't had to fill out a form like
18 that, no.

19 **Q. Are you aware if any exists?**

20 A. We do, I believe, have a form on the
21 floor. I've seen other nurses fill one out where
22 they need to go to other routes of communication.

23 **Q. So that form is only filled out if a**
24 **nurse feels like there should be other routes of**
25 **communication?**

1 MR. YOUNG: Object to the form.

2 You may answer.

3 A. Oh, sorry. You know, I'm not sure. I
4 haven't had to fill one out. So I feel like, I
5 think, the nurse would fill that out if they felt
6 like they were not able to effectively communicate
7 with the patient.

8 Q. Is that based on assumption or based on
9 what you know?

10 A. That's how we're taught. That's the
11 process we're taught to go through when there are
12 barriers to communication, but I haven't had to do
13 it, so.

14 Q. So are you saying that if the
15 communication tool form is filled out, that means
16 that a nurse has a sense that someone can not
17 communicate effectively in English so that an
18 interpreter is needed?

19 A. That some sort of, yes, that would be
20 my assumption, that some sort of interpretation may
21 be required at times if that form is filled out.

22 Q. You said at times. What do you mean?

23 A. It's not always required. I mean, like
24 I've told you about patients that I've had before,
25 sometimes they're able to communicate effectively

1 in a language for the basis of the questions that
2 you're asking. So if it's a simple yes or no
3 question, if it's asking them, you know, to rate
4 their pain level, you know, are you in pain? A lot
5 of people can say yes or no to that or convey an
6 answer to that without necessarily having to go
7 through an interpreter.

8 Q. Okay. Are you trained on what the
9 risks are of using family members as interpreters?

10 A. Yes.

11 Q. What are the risks?

12 A. The risk is that the family member
13 might edit the questions that you're asking. They
14 might edit the patient's response. So usually it's
15 best to have a non-biased interpreter.

16 Q. And also there's no way -- are you
17 trained that there's no way of assessing if they
18 have the sufficient medical terminology to be able
19 to communicate with the patient?

20 A. Yeah. I mean, there's no way to know
21 what their background is or if they have medical
22 terminology to communicate to the patient.

23 Q. Did you review any records to prepare
24 for today?

25 A. Yes.

1 Q. What records did you review?

2 A. I looked at my charting.

3 Q. How many pages of charting did you
4 review, approximately?

5 A. It was probably 10 maybe.

6 Q. Okay. Do you know who Scott Tomei is?

7 A. I do.

8 Q. Do you have a memory of him?

9 A. I do have a memory of him.

10 Q. And is he a deaf man?

11 A. Yes.

12 Q. Do you understand that he communicates
13 in sign language?

14 A. Yes, primarily.

15 Q. Okay. And during your time with Mr.
16 Tomei, did you ever use a professional sign
17 language interpreter?

18 A. Not to my knowledge. There was someone
19 in the room with him who was able to translate, as
20 far as I know, they were not a professional, but I
21 don't know that to be certain.

22 Q. So do you know who these people were in
23 the room?

24 A. Not by any introduction or introduction
25 that I remember in the room.

1 Q. Okay. So you don't know if this was a
2 stranger, friends, family, somebody else?

3 A. I don't know their relationship to him.
4 I assumed they were family because he, obviously,
5 wanted them in the room with him. But I didn't get
6 an introduction or a name that I recall.

7 Q. Did you assess the abilities of the
8 person that was in the room signing to Mr. Tomei?

9 A. Not that I recall. I don't remember
10 doing that.

11 Q. And did you see Mr. Tomei on October
12 24, 2017 admission to the 27th, 2017 admission?

13 A. I believe I had him on the night of
14 October 26th, so that's kind of in between there.

15 Q. Okay.

16 A. I took care of him starting at about
17 6:45 to 7 p.m. on the night of the 26th through the
18 morning of the 27th.

19 Q. I'm going to hand you what's been
20 previously marked as Exhibit-1. It's the medical
21 records. Can you show me where your notes are in
22 this?

23 (Witness complies.)

24 A. This may take a while.

25 Q. Sure.

1 MR. YOUNG: Do you want her to review
2 the whole chart?

3 MR. ROZYNSKI: Yes.

4 MR. YOUNG: I think we have a several
5 hundred page chart here. And she's being asked to
6 make sure every single page in which her name may
7 appear. I think it's unfair on that basis.

8 Q. What page are you on?

9 A. 90. I can't be sure that there's
10 nothing I've missed, but I have not seen -- I'm
11 looking for what I know the pages look like that
12 have my charting on them and I've not found them.

13 Q. You're still looking? You found
14 something on 90?

15 A. There's my name. That would be his
16 rhythm strip.

17 Q. What page is that on?

18 A. 92.

19 Q. Okay. As you see them, just let me
20 know.

21 A. There's my initials on his medical --
22 on his MAR, where we administered medications. So
23 he had medicines from me at 21:30 on the 26th and
24 at 4:16 on the 27th.

25 Q. Okay.

1 A. And also at -- it just says times two.
2 There's my initials, yes, 21:30, 23:35, 2:08 and
3 4:16 for medication administration, morphine.

4 On page 113 here's my name.

5 Q. Okay. So on 113 at 10/27 at 5:47 a.m.,
6 you say the patient is deaf?

7 A. Yes.

8 Q. Okay. And the whole outcomes and
9 goals, it says communication. Did you write that
10 in?

11 A. I did not write that in. This is -- we
12 have a click system for palliative care where you
13 tick off a nursing diagnosis and the goals.
14 Honestly, this is an old system. We don't have
15 this system any more, so I don't remember. It's
16 not -- you don't write anything in, you can tick
17 off a goal, as well as ticking off the nursing
18 diagnosis.

19 Q. Did you tick off improve communication
20 in the nursing diagnosis?

21 A. According to my charting, yes. This
22 would have been -- I'm sorry. Nursing notes is
23 impaired communication.

24 Q. Okay. Do you know why you ticked off
25 impaired communication for Mr. Tomei?

1 A. Because he was deaf.

2 Q. Okay. Do you know if he could lip
3 read, or write or something else?

4 A. I don't know. I don't remember.

5 Q. Okay. So when you have a nursing
6 diagnosis of impaired communication, how do you --
7 how do you improve the communication as an outcome
8 or goal?

9 MR. YOUNG: I object. I think it could
10 misstate prior testimony.

11 A. Can you repeat the question? I'm
12 sorry.

13 Q. So nursing diagnosis said impaired
14 communication, correct?

15 A. Yes.

16 Q. And outcomes and goals it says
17 communication?

18 A. Yes.

19 Q. So is the outcome and goal to improve
20 communication?

21 A. The outcome or goal is to have
22 sufficient communication with the patient.

23 Q. Okay. The interventionist team, POC,
24 what does that mean?

25 A. Team palliative care.

1 Q. Does that have anything to do with
2 having communication?

3 A. I don't remember his specific plan of
4 care.

5 Q. Okay.

6 A. That's all I can say.

7 Q. Do you know if you provided a video
8 interpreter to Mr. Tomei?

9 A. I do not remember providing a video
10 interpreter to him.

11 Q. Okay. Would the palliative care be
12 somewhere in his chart for this communication
13 improvement or impairment?

14 A. Yeah, I guess it could be.

15 Q. All right. Well, let's keep on going
16 to where your entries show up.

17 A. Page 116.

18 Q. Okay. So speech, you write patient is
19 deaf. What does that mean? What does that have to
20 do with his speech?

21 A. It just says that he's deaf.

22 Q. So why does it say speech there?

23 A. That's just where I entered it in on
24 the chart.

25 Q. Do you know if his speech was impaired

1 or not?

2 A. I don't. I'm sure -- I'm trying to
3 remember if he spoke. I don't remember him -- I
4 feel like I spoke some, you know, that he was able
5 to nod or, you know, make affirmative communication
6 to me, but I can't recall the specifics of his
7 speech.

8 Q. Okay. Do you have any other entries on
9 this page?

10 A. I mean, this whole page, this is the
11 assessment that I charted on him.

12 Q. Okay. So speech, it says garbled. Did
13 you write that?

14 A. Oh, yes.

15 Q. So he didn't have clear speech?

16 A. Not according to my charting.

17 Q. Is that a response to voice? Does that
18 mean he could hear?

19 A. Yeah. I mean, I did tick voice and
20 touch, but it's my understanding that he can not
21 hear.

22 Q. Okay. So there's a Glasgow Coma score?

23 A. Uh-huh.

24 Q. Best verbal five. What does that mean?

25 A. That means that the patient is

1 oriented. It says oriented slash verbalize, but
2 oriented. You're able to assess that they know
3 where they are.

4 Q. So did he verbalize that to you?

5 A. I don't remember him verbalizing it,
6 but you can't separate the orient from the verbal.
7 It's just a tick in the chart. So I would have
8 ticked that he was oriented and that he knew where
9 he was.

10 Q. So was he obeying verbal commands from
11 you?

12 A. Not from me, but there was a companion
13 in the room that when I was doing my assessment and
14 I would ask him to, you know, squeeze my fingers,
15 look this way, he was able to do those things
16 through the companion that was interpreting.

17 Q. So the companion wasn't verbalizing to
18 him?

19 A. I think he was signing. He was signing
20 with the woman in the room.

21 Q. The gentleman that was there was a
22 companion who was signing?

23 A. It was a female.

24 Q. Okay. Where else are you? Are you on
25 the next page?

1 A. Yes.

2 Q. How about on the next page?

3 A. Yes.

4 Q. So the education, we're on page 118,
5 right?

6 A. Yes.

7 Q. Education: Teach back, patient and
8 family discussed?

9 A. Yes, that's what it says.

10 Q. How did you do teach back with Mr.
11 Tomei?

12 A. So this is on our fall risk assessment.
13 So it's, basically, saying that you educated the
14 patient and the family on the level one
15 interventions for a fall. So that the side rails
16 are to remain up, that they're oriented, that they
17 know where their call light is, belongings are in
18 reach, things like that.

19 And then the education part is how you
20 know that they understood that, and that they are
21 able to understand what you've talked to them and
22 they could say affirmative to yes will do these
23 things.

24 Q. Do you know how he did that from your
25 memory without looking?

1 A. From memory, I would assume that my
2 main recollection of Mr. Tomei is communicating
3 through the companion in the room that was signing.

4 Q. Did you ever ask Mr. Tomei if he ever
5 wanted a professional interpreter?

6 A. I do not recall asking him if he wanted
7 one. He never asked me for one, but I don't
8 remember asking him if he wanted one.

9 Q. Okay. Is the protocol at Parkwest to
10 not offer an interpreter, but to wait for one to be
11 asked for?

12 A. I'm not certain of the specific
13 protocol.

14 Q. Is it your understanding that you
15 should only wait for a request rather than offer an
16 interpreter?

17 A. I'm trained to, if I'm able to
18 effectively communicate what I need to, then I'm
19 trained to do that. But if I feel that the
20 communication is ineffective, then I can go down
21 the routes of working in some of those tools or at
22 any time if the patient asks me to use those tools.

23 Q. Okay. Let's go to page 120. It says
24 10/26/17 at 21:12, emotional status PMW. Is that
25 you?

1 A. Yes.

2 Q. Patient unable to communicate as he is
3 deaf.

4 A. Uh-huh.

5 Q. Is that what it says?

6 A. Yes.

7 Q. And you wrote that?

8 A. I typed it in.

9 Q. You typed that in?

10 A. It looks like it, yes.

11 Q. Okay. So it was your assessment that
12 you were unable to communicate with him because
13 he's deaf?

14 MR. YOUNG: Objection. Misstates
15 question.

16 Go ahead and answer.

17 A. I was able to communicate with the
18 patient. I should have, you know, put verbally
19 communicate with me, but I felt like I was able to
20 communicate with him.

21 Q. So you would have written that patient
22 unable to communicate as he is deaf if, in fact,
23 you could communicate with him even though he was
24 deaf?

25 MR. YOUNG: Same objection.

1 A. I should have added verbally
2 communicate, you know, as in speech.

3 **Q. What's emotional status assessment?**

4 A. Just where you are assessing the
5 patient's emotional status.

6 **Q. And is that by asking him questions?**

7 A. Usually not. It's usually by observing
8 the patient, seeing if they're distressed, if
9 they're happy, sad, in pain.

10 **Q. When you do an emotional status**
11 **assessment, you don't ask a person how they're**
12 **feeling or if there's anything bothering them, or**
13 **if they feel any stress or anything? You never ask**
14 **that for patients?**

15 A. Yes, yeah.

16 **Q. You do ask that of patients?**

17 A. It comes out through the questioning in
18 other parts of your assessment. You're asking them
19 how they're feeling, if they have pain.

20 **Q. Okay. Were you able to do that with Mr.**
21 **Tomei or were you unable to do that because he's**
22 **deaf?**

23 A. I was unable to get a verbal response
24 from him due to his deafness and his level of
25 speech. But that doesn't mean you can't still put

1 down what you assess as emotional status. As I
2 said before, sometimes you can do that by observing
3 the patient, plus seeing their demeanor, if they're
4 coping.

5 Q. But you didn't put anything about what
6 your observations were in your emotional status
7 assessment, right?

8 A. It does not look like I did.

9 Q. Okay. So you were not able to
10 ascertain either by observation or communicating
11 with Mr. Tomei?

12 A. According to the chart it says other.
13 And then just, you know, just the comment that he
14 is deaf.

15 Q. And that you're unable to communicate
16 with him.

17 MR. YOUNG: Objection. Misstates prior
18 testimony.

19 Go ahead.

20 A. It says patient unable to communicate,
21 not that I was unable to communicate with him.

22 Q. Okay. So if he can't communicate with
23 you, isn't communication a two-way street?

24 A. Yes. And as I said earlier, I should
25 have typed in verbally as well, but I did feel that

1 we were able to communicate.

2 Q. Okay. So when you put other for
3 emotional status, that allows you to do free text?

4 A. Yes.

5 Q. And so you put other. And then you put
6 free text, patient unable to communicate as he is
7 deaf?

8 A. Yes.

9 Q. So you could have ticked off your
10 observations, but you did not, right?

11 A. It appears that way, yes.

12 Q. Okay. Do you have a specific
13 recollection of your interaction with him during
14 this emotional status assessment?

15 A. Not necessarily at 21:20 exactly, but I
16 have a recollection of his emotional status
17 throughout the night, yes.

18 Q. So if you assess that Mr. Tomei can not
19 communicate with you verbally, did you offer him an
20 interpreter?

21 A. I don't remember offering him an
22 interpreter, because I felt I was able to
23 effectively communicate the answers that I needed,
24 for what I needed to do that night through his
25 companion who was signing with him.

1 Q. Okay. So even though you are unable to
2 do an emotional status observation of Mr. Tomei,
3 you still -- and you noted that the patient is
4 unable to communicate as he is deaf, you still felt
5 like you could communicate with him?

6 MR. YOUNG: That partially misstates
7 partial testimony.

8 Go ahead.

9 A. I felt I could communicate with him and
10 assess his emotional status that night.

11 Q. But that's not noted in your record.

12 MR. YOUNG: Objection.

13 A. No.

14 Q. Okay. And are you trained by Parkwest
15 that if you're unable to communicate for any reason
16 that you should offer an interpreter?

17 A. Yes. If we're unable to communicate
18 effectively, we are trained to offer some of our
19 translating tools.

20 Q. Okay. And would you agree there's no
21 offer of an interpreter in this note?

22 A. I do not remember offering him an
23 interpreter.

24 Q. Okay. Where else is your entries? I'm
25 sorry, entries?

1 A. 121.

2 Q. Okay.

3 A. 122.

4 Q. All right.

5 A. 123.

6 Q. Okay. So let's go back to 123. At
7 10/27/17 at 2:35 it says: "Patient pain worsening
8 and meds are not relieving pain. Patient very
9 uncomfortable. VS stable." What does VS mean?

10 A. Vital signs. And, yes, that's what it
11 says. That's the note from 2:35 a.m. on 10/27.

12 Q. So Mr. Tomei was still struggling with
13 uncontrolled pain at four milligrams of morphine?

14 A. Yes.

15 Q. Does that indicate to you that Mr.
16 Tomei was in a lot of pain?

17 A. Yes, absolutely, he was in a lot of
18 pain.

19 Q. Did you ask Mr. Tomei to describe his
20 pain?

21 A. I don't remember asking him to describe
22 it. It was obvious to me that he was in a lot of
23 pain.

24 Q. How was it obvious?

25 A. He was very -- my memory of him that

1 night is him being extremely uncomfortable, you
2 know, just restless in the bed, you know,
3 complaining, moaning, he was very uncomfortable.

4 Q. Okay. Where else does your name pop
5 up?

6 A. It's page 125.

7 Q. Okay.

8 A. Page 126.

9 Q. All right.

10 A. 127.

11 Q. Okay.

12 A. 128.

13 Q. So Mr. Tomei had an order for Dilaudid?

14 A. Dilaudid.

15 Q. And what is that?

16 A. It's a pain medication.

17 Q. Is that stronger than morphine?

18 A. Yes.

19 Q. Do you know why he was prescribed that?

20 A. Because I contacted the doctor during
21 the night because the morphine was not controlling
22 his pain. So I called and got an order for
23 Dilaudid, it looks like at 5:14 a.m..

24 Q. Okay. Where else in the chart?

25 A. I only took care of him on the night of

1 the 26th and into the early morning of the 27th.

2 MR. YOUNG: Do you mind if I step out
3 while she's doing that?

4 MR. ROZYNSKI: Sure.

5 Q. If you find any other pages just put it
6 off to the side.

7 (A recess transpired.)

8 Q. Okay. You said 198?

9 A. Yes, I see my initials. It looks like.
10 I'm not familiar with the way this page is laid
11 out, but it looks like it's for when I put calls
12 into the doctor to try and get additional pain
13 medications ordered for him. And it's got the note
14 from 2:30 and from 4:38.

15 Q. When a patient is in that much pain, is
16 the only important thing to ask the patient, what
17 is your pain level from zero to 10?

18 A. I wouldn't say that's the only
19 important thing. It's certainly the most
20 important.

21 Q. Okay. Are there other things you
22 typically ask patients who are in a lot of pain,
23 other than tell me from zero to 10 what your pain
24 level is?

25 A. I mean, you can ask them other things

1 about their pain, but if they're able to give you a
2 number and show you where or indicate where they're
3 hurting, that's the most important part of the
4 assessment.

5 Q. What other questions do you ask about
6 pain, other than what is your pain level from zero
7 to 10?

8 A. You can ask when did it start? Have
9 you been having it for a while?

10 Q. How about where is the pain coming
11 from? Is that something?

12 A. Yes, that's something.

13 Q. Is it a dull pain or sharp pain?

14 A. You could ask those questions, yes.

15 Q. Is the pain spreading?

16 A. We ask the location of the pain and how
17 long it's been there. And so if they're able to
18 indicate that it's going to other places, then yes.

19 Q. Is that important to know if it is
20 spreading or getting worse in other places?

21 A. Yes.

22 Q. Could that indicate that the condition
23 is getting worse if the pain is spreading to other
24 places?

25 A. It could indicate a lot of things. It

1 could indicate there are other issues. It could
2 indicate referred pain, but yes.

3 Q. Okay. So that could help diagnose
4 other ailments if you know that the pain is
5 spreading to other places?

6 A. If you know that they're having pain in
7 other places than what they've first identified,
8 yes.

9 Q. So there are questions or inquiries of
10 value when someone has pain, other than what's your
11 pain level other than zero to 10?

12 A. Yes.

13 Q. That can assist in having better
14 treatment for a patient?

15 A. Yes.

16 Q. And is it helpful for the patient to be
17 able to describe it in detail, their pain?

18 A. It can be.

19 Q. On page 202, 10/27/17 at 2:35 a.m.,
20 interventions BMW?

21 A. Yes.

22 Q. Attempting to call physician for
23 vascular surgery?

24 A. Yes.

25 Q. What does that mean?

1 A. That means that I would have called
2 their on- call pager. And waiting for a call back.

3 **Q. Is this just to get orders for stronger**
4 **pain medicine or are you asking for surgery at this**
5 **time?**

6 A. Well, his admitting doctor was in the
7 vascular surgery group. So I was calling the
8 on-call physician for the vascular surgery group,
9 is what that means. So I was just attempting to
10 contact whoever was on call for the attending
11 physician. And it's my recollection that I was
12 calling to inform them of the level of pain that
13 Mr. Tomei was having, and that the current pain
14 medications were not giving him adequate pain
15 relief.

16 **Q. Is there anything stronger than**
17 **Dilaudid?**

18 A. Dilaudid.

19 **Q. Dilaudid?**

20 A. Yes, but not that we give on the floor.

21 **Q. Okay. What is Dilaudid the strongest**
22 **that you can give on the floor?**

23 A. It's the strongest that I've given on
24 the floor. I don't know that I would say it's the
25 strongest that can be given on the floor, but it is

1 certainly a step up above morphine.

2 Q. What are the typical cases that you're
3 aware of that you've given Dilaudid for?

4 A. We give Dilaudid for vascular patients.
5 We give Dilaudid for patients who have an allergy
6 to morphine. We give Dilaudid, I'm trying to
7 think.

8 Q. How about burn victims?

9 A. I've never taken care of a burn victim.

10 Q. Okay. What other types of vascular
11 cases that you have given Dilaudid?

12 A. Where there's just, like, where there's
13 a blood clot obstructing blood flow, that's usually
14 -- that's the most common case that I've given.

15 Q. Was Mr. Tomei given Fentanyl?

16 A. Not by me.

17 Q. Is Fentanyl a step up from Dilaudid?

18 A. Yes.

19 MR. YOUNG: Object to the extent that
20 it may call for an expert opinion for which I'm not
21 sure this witness has yet been established as.

22 You may answer to the extent you know.

23 This is, obviously, beyond any 30(b)6
24 testimony.

25 A. What was the question again?

1 Q. Is Fentanyl a step up from Dilaudid?

2 MR. YOUNG: Same objection, but you can
3 answer.

4 A. To my understanding it is. I've never
5 given Fentanyl. It's usually given in the PACU,
6 like, post surgical patients. And those orders are
7 always discontinued by the time the patient would
8 arrive on the floor of my unit.

9 Q. Has your name popped up anywhere else?

10 A. Yes, 232.

11 Q. What's that?

12 A. It looks like this is his list of
13 orders for his diet, for his lab work, for his
14 medications. So this would have been just me
15 confirming his order set. So it's just got me
16 listed up at the top there. This continues with
17 just all of his orders, more lab work. My name is
18 just at the top of all of them because I confirmed
19 his orders. Here's an order for Dilaudid. It has
20 me at the top of all of those pages as far as
21 confirming those orders. And the last page is 238.

22 Q. Okay. And then it starts the day shift
23 nurse. Was there anything that you reviewed in
24 your preparation for today in terms of medical
25 records that you haven't already seen?

1 A. I don't know.

2 Q. Anything that stands out to you,
3 anything of significance?

4 A. No.

5 MR. ROZYNSKI: I don't have any other
6 questions. Thank you.

7 MR. YOUNG: I'm going go to step out
8 with Devon and I'll decide whether I want to ask
9 any questions.

10 (A recess transpired.)

11 MR. YOUNG: No questions.

12 (Deposition was concluded at 11:29
13 a.m.)

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1 C E R T I F I C A T E

2 STATE OF TENNESSEE

3 COUNTY OF KNOX

4 I, Catherine Golembeski, Licensed Court
5 Reporter and Registered Professional Reporter, do
6 hereby certify that I reported in machine shorthand
7 the deposition of MARIE PATTERSON WILSON, called as
8 a witness at the instance of the Plaintiff, that
9 the said witness was duly sworn by me; that the
10 reading and subscribing of the deposition by the
11 witness was waived; that the foregoing pages were
12 transcribed under my personal supervision and
13 constitute a true and accurate record of the
14 deposition of said witness.

15 I further certify that I am not an attorney
16 or counsel of any of the parties, nor an employee
17 or relative of any attorney or counsel connected
18 with the action, nor financially interested in the
19 action.

20 *Cathy J. Golembeski*

21 Catherine Golembeski, LCR# 778
22 Registered Professional Reporter
23
24
25

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